STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155787	A. BUILDING 00 B. WING	10/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA VETERANS HOME	3851 N RIVER RD WEST LAFAYETTE, IN 47906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This Visit was for the Investigation of Complaint(s) IN00118060, IN00117265, and IN00117419. Complaint IN00118060-Substantiated. Federal/state deficiencies related to the allegation(s) are cited at F157, F309 and F 386. Complaint IN00117265-Unsubstantiated due to lack of evidence. Complaint IN00117419-Substantiated. No deficiencies related to the allegation(s) are cited. Unrelated deficiencies are cited. Survey date(s): October 22, 23, 24, & 25, 2012 Facility number: 001134 Provider number: 155787 AIM number: 200817200 Survey Team: Lora Brettnacher, RN, TC Christi Davidson, RN Census bed type: SNF/NF: 166 NCC: 23	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Total: 189 Census payor type: Medicare: 20 Medicaid: 126 Other: 43 Total: 189 Sample: 7 Supplemental Sample: 15 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 10/29/12 Cathy Emswiller RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to inform a resident's family and/or consult with the resident's physician when a resident had a significant change in blood pressure	F0157	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?The Physician was notified of the change of condition of resident on	11/24/2012

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	which had the potential for requiring physician intervention for 1 of 3 residents reviewed for physician/family notification (Resident #C). Findings: Resident #C's record was reviewed on 10/23/2012 at 10:00 A.M. Resident #C was admitted to the facility on 12/2/10 and had current diagnoses which included but were not limited to prostate cancer with supra pubic catheter, recurrent urinary tract infections, diabetes mellitus, history of atrial fibrillation, hypertension, and congestive heart failure. Resident #C was alert and oriented. He was being followed by a nephrologist (kidney specialist) regarding the recurrent urinary tract infections. Resident #C's nurse's notes from 7/1/2012 through 9/12/2012 were reviewed. Resident #C's "Vital Sign Flow Sheet" for the dates 8/20/2012 through 9/8/2012 were reviewed. On 9/6/2012, Resident #C's blood pressure which averaged 100/60 was 62/42 and his oxygen saturation which averaged in the high 90's on room air was 90% on room air. His temperature was documented as 99.3. On 9/5/2012 it was 96.4. Documentation of physician notification was lacking in Resident # C's record. The record did not		10/24/12. One Nurse Practitioner was terminated prior to 10/24. Physician discussed with the other Nurse Practitioner about the documentation needed. IVH will add with the credentialing packet for Nurse Practioners to sign off they read the Code and will have the Nurse Practitioners sign off stating they understand prior to starting on the contract with IVH. Physician will review charts for the Nurse Practioners on an on-going basis.2. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?All other resident's clinical records have been reviewed for significant changes. Proper documentation was put into place, including Physician and responsible party notification. This was done 11/2/12.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?The vital signs flow sheet has been revised to indicate the nurse's signature area. There has also been a section added to the vital sign flow sheet for a re-take of and abnormal vital sign. The Physician has given parameters for each area of vital signs for which he wishes to be called on, for above or below those parameters. A new policy has been written for these parameters. This policy has been	

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	have times of when the vitals were taken or initials of who took the vitals. During an interview on 10/24/2012 at 10:10 A.M., the DON (Director of Nursing) indicated any one who was being followed by a nephrologist (kidney specialist) had their vitals taken at a minimum of once daily. The CNAs (Certified Nursing Assistants) took the vitals and documented them on the frequency form. Nurse's were responsible to check the book daily. If the vitals were abnormal the CNAs were to immediately report the vitals to the nurse. The nurse then would assess and notify the physician if needed. Documentation should be in the nurse's notes and a notification form the facility files in a folder for the physician's to look at when they were at the facility. The DON was asked to provide documentation the physician and or family was notified of the abnormal vitals on 9/6/2012. During an interview on 9/24/2012 at 12:20 P.M., the DON indicated she could not find documentation of the physician or family being notified of the abnormal vitals. She indicated she spoke with the nurse who cared for Resident #C on 9/6/2012 and she could not recall being aware of the abnormal vitals. The DON indicated because there were no initials		in-serviced to all nursing staff and the medical group. The will be done by 11/14/12.4. How will the corrective action be monitored to ensure the deficient practice will not recur?The nurse unit managers and supervisors will audit all vital sign flow sheets daily x 30 days, weekly x one month, monthly x 3 months, then quarterly there after to manage any discrepancies in the policy. This will start on 11/1/12. This will be reported to QA monthly for 3 months and then quarterly thereafter.	

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	on the vitals form she could not find out who documented the vitals. The DON indicated two Nurse Practitioners (NP) were here on 9/6/2012. NP #1 addressed Resident #C's indigestion and gave orders for an antacid. The DON called NP #1 and she indicated NP #1 told her she did not recall being told about any abnormal labs. NP #1 did not write a progress note for this visit. The DON called NP #2. NP #2 indicated to the DON she did not remember being told about the abnormal vitals. NP #2 indicated to the DON she only recalled consulting with Resident #C regarding his DNR (do not resuscitate) status. She did not write a progress note for this visit. A current facility policy titled "Physician contact" provided by the DON on 10/22/2012 indicated, ". . .STAT PHYSICIAN CONTACT. . .The following symptoms/signs and examples of situations that require immediate notification are not to be all-inclusive. If unsure about the situation, notify the physician/NP. . .Change in vital signs outside ordered parameters or general guidelines: Blood pressure greater than 200 systolic or less than 90 diastolic. . ." This Federal tag relates to Complaint IN00118060.			

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	3.1-5(a)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to thoroughly assess a resident with an abnormal blood pressure for 1 of 3 residents reviewed for death (Resident #C). Findings: Resident #C's record was reviewed on 10/23/2012 at 10:00 A.M. Resident #C was admitted to the facility on 12/2/10 and had current diagnoses which included but were not limited to morbid obesity, prostate cancer with a supra pubic catheter, recurrent urinary tract infections, diabetes mellitus, history of atrial fibrillation, history of gastroesophageal reflux, hypertension, anemia, multiple lower extremity wounds, depression, and congestive heart failure with bipedal edema. Resident #C was alert and oriented. He was being followed by a nephrologist regarding the recurrent urinary tract infections and kidney disease.	F0309	1. What corrective action will be accomplished for those residents to have been found to have been affected by the deficient practice? Physician was notified of abnormal blood pressure and change in other vital signs on 10/24/12.2. How will others having the potential to be affected by the deficient practice be identified and what corrective action will be taken?All vital signs flow sheets were reviewed for abnormal vital signs. The Physician set new parameters for all vital signs and any abnormal were reported to the Physician / Nurse Practitioner and family. This was done by 11/2/12.3. What systemic changes will be made to assure the deficient practice does not occur again? New parameters were set for all vital signs by the Physician. Baseline vital signs were determined for all current residents and will be determined for all new residents after one month. Policy changes were made regarding follow up assessment of residents being sent to the hospital for condition	11/24/2012

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	Resident #C's nurse's notes from 7/1/2012 through 9/12/2012 were reviewed. Resident #C's "Vital Sign Flow Sheet" for the dates 8/20/2012 through 9/8/2012 were reviewed. On 9/6/2012, Resident #C's blood pressure which averaged 100/60 was 62/42 and his oxygen saturation which averaged in the high 90's on room air was 90% on room air. His temperature was documented as 99.3. Documentation of an assessment was lacking in Resident #C's record. The record did not have times of when the vitals were taken or initials of who took the vitals. During an interview on 10/24/2012 at 10:10 A.M., the DON (Director of Nursing) indicated any resident who was being followed by the nephrologist (kidney specialist) had their vitals taken at a minimum of daily. The CNAs (Certified Nursing Assistants) took the vitals and documented them on the frequency form but it was the nurses responsibility to check if they were done and what they were. If the vitals were abnormal the CNAs were to immediately report the vitals to the nurse. The nurse then would assess and notify the physician if needed. If something was abnormal for a resident, documentation should be in the nurse's notes and on a notification form the facility filed in a		changes. All parameter changes, determination of baseline vital signs, and policy changes will be in-serviced to all nurses, QMAs, CNAs, and the medical group by 11/14/12.4. How will the changes be monitored for effectiveness? All vital sign flow sheets will be monitored by the nurse unit manager daily x 4 weeks starting 11/1/12, then monthly x 3 months, then quarterly thereafter and results reported to QA. Any patient sent out to the hospital for a change in condition will result in an audit of the assessment and follow up assessment on vital signs and condition for each send ou for 30 days by the nurse unit manager, beginning 11/5/12. After the first 30 days, 50% of send outs on each unit will be randomly audited by the nurse unit manager for 3 months, then 50% of each unit randomly audited by the nurse unit manager quarterly thereafter. All results will be reported to QA.	

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	folder for the physician's to look at when they were at the facility. The DON was asked to provide documentation Resident #C was assessed at the time of the abnormal vitals on 9/6/2012. During an interview on 9/24/2012 at 12:20 P.M., the DON indicated she could not find documentation of Resident #C being assessed due to the low blood pressure. She indicated she spoke with the nurse who cared for Resident #C on 9/6/2012 and she could not recall being aware of the abnormal vitals. The DON indicated because there were no initials on the vitals form she could not find out who documented the vitals. The DON indicated two Nurse Practitioners (NP) were here on 9/6/2012. NP #1 addressed Resident #C's indigestion and gave orders for an antacid. The DON called NP #1 and she indicated NP #1 told her she did not recall being told about any abnormal labs. NP #1 did not write a progress note for this visit. The DON called NP #2. NP #2 indicated to the DON she did not remember being told about the abnormal vitals. NP #2 indicated to the DON she only recalled consulting with Resident #C regarding his DNR (do not resuscitate) status. She did not write a progress note for this visit. The next documented blood pressure was			

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	on 9/7/2012 (no time) and was 95/46. The record lacked documentation of Resident #C being assessment at this time. The only nurse's note dated for 9/7/2012 documented dressing changes to Resident #C's wounds. A current facility policy titled "Physician Contact" provided by the DON on 10/22/2012 indicated a blood pressure greater than 200 systolic (top number) and less than 90 diastolic (bottom number) was outside the general guidelines for a blood pressure. During an interview on 10/24/2012 at 1:55 P.M., LPN #4 indicated CNAs should report to a nurse immediately if a resident's blood pressure was 62/42. During an interview on 10/24/2012 at 1:58 P.M., CNA #9 indicated she would immediately tell a nurse if a resident's blood pressure was below 90/70. She would have immediately told a nurse if it was 62/42. During an interview on 10/24/2012 at 2:05 P.M., LPN #5, LPN #6 , and LPN #10, all indicated if they were told a resident's blood pressure was abnormal they would recheck the blood pressure themselves and assess the resident. When asked if a CNA wrote the vitals in the			

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	frequency book without telling a nurse what would they do. They all indicated they were to check the frequency book during their shift to make sure the vitals were completed. During an interview on 10/24/2012 at 2:12 P.M., CNA #10 indicated if the blood pressure was abnormal she would take it again and then tell the nurse. She indicated anything below 112/48 or 98/50 was abnormal and would be verbally told to a nurse. A nurse's note dated 9/8/2012 at 8:20 A.M., indicated, "complaining of chest pain-vitals 98.6 86-18-103/61-94% on room air. . .given dose of ES Maalox and told if it didn't help let staff know. A nurse's note dated 9/8/2012 8:50 A.M., indicated, "States chest still hurts-call placed to supervisor, then MD." A nurse's note dated 9/8/2012 at 9:20 A.M. indicated, "NP returned call-new RXs (orders) received." A nurse's note dated 9/8/12 at 9:25 A.M. indicated, "Resident stated chest pain was letting up-wanted Nitro SL (sublingual) anyway, which was given." The record lacked documentation of a thorough assessment of Resident #C's condition including vitals with his continued			

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	complaints of chest pain.. A nurse's note dated 9/8/2012 at 12:10 P.M. indicated, "Put in w/c (wheel chair) for lunch-complained of chest pain-P 91, R 20, B/P 67/45, O2 Sat 98%-sleeping in w/c-unable to give nitro due to decreased B/P. (Dr. Named) notified and RX (order) received to send to ER for evaluation-nursing supervisor was notified prior to MD." A nurse's note dated 9/8/2012 at 12:40 P.M. (30 minutes after the order was received to send Resident #C to ER) indicated, "call placed to ambulance." The record lacked documentation of an assessment or a second blood pressure after the 12:10 P.M. blood pressure of 67/45 was documented. A nurse's note dated 9/8/2012 at 1:00 P.M. indicated, "Ambulance here for pick-up." A nurse's note dated 9/8/2012 at 5:45 P.M. indicated, Resident #C's wife called the facility and informed them Resident #C was being admitted to the hospital with complete renal failure. A nurse's note dated 9/15/2012 titled Discharge summary indicated Resident			

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	#C was sent to the emergency room on 9/8/2012. Labs were drawn and he was found to be in renal failure. The patient was admitted, had multi-organ failure, which led to the election of hospice care. The patient expired on 9/12/2012. A facility policy titled "Vital Signs" provided by the Superintendent on 10/23/12 indicated: "It is the intent of the Indiana's Veterans' Home (IVH) that all Nursing Home Care residents shall have their vital signs and weight taken and recorded at least monthly and as needed. although nurses aides and Qualified Medical Assistants may take resident vital signs, any abnormal vital signs are to be immediately reported to the nurse." This Federal tag relates to Complaint IN00118060. 3.1-37(a)			

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F0323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the spacing between the bed rails and mattress or spacing between the bars of the bed rails met safety requirements for 15 of 189 beds used in the facility. (#I, #J, #K, #L, #M, #N, #O, #P, #Q, #R, #S, #T, #U, #V, #W) Findings include: Facility wide rounds in the presence of the DoN, RN #2 and RN #3 were conducted on 10/24/12 at 2:30 p.m. until 4:00 p.m. to review the safety of all resident beds and to identify resident beds with unsafe bed rail zones or unsafe mattress zones with the potential for entrapment. 1. The record for Resident #I was reviewed on 10/25/12 at 10:59 a.m. Diagnoses included but were not limited to diabetes and hyperlipidemia. A nurses note dated 10/21/12 at 0300	F0323	1. What action was taken to correct the deficient practice?The bed was removed from the room immediately and replaced with the proper bed with the acceptable railing.2. How are other identified and what corrective action will be taken to prevent it from occurring again or to others?All residents' beds on campus were inspected for unacceptable measurements regarding the rail safety and all beds that did not meet specifications were removed. IVH implemented a "Bed Rail Zones, Appropriate Dimensions and Appropriate Usage" policy and trained all employees on the 7 zones of entrapment.3. What measures or systemic changes were put into place to be sure this does not reoccur?The policy states that all beds will be audited every quarter by the Safety Officer. All 7 zones will be checked and documented and turned into the Physical Plant Director for auditing purposes.4. How will corrective actions be monitored?Quarterly PMs will be sent to the Safety Officer to check all beds per policy and document on a log. The measurement log	11/24/2012

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	[3:00 a.m.] indicated, "...Speech clear, able to make needs known...Ambulating, gait steady. ADL's [activities of daily living] per self [sign for with] supervision." During an observation on 10/24/12 at 2:21 p.m., Resident #I was sitting on his bed with bilateral upper side rails raised. Bilateral lower side rails were attached to the bed but not in the raised position. One of the upper raised side rails had three large open areas greater than 4 3/4 inches within the rail, and both of the lower rails each had three large open areas greater than 4 3/4 inches within the rails. During an observation on 10/24/12 at 2:26 p.m., the DoN measured each of the three large open areas with a tape measure on the upper side rail and both of the lower side rails. Within the side rails on Resident #I's bed the measurements of those openings were 7.75 inches by 8.0 inches each. 2. The record for Resident #J was reviewed on 10/25/12 at 11:02 a.m. Diagnoses included but were not limited to asthmatic bronchitis and difficulty sleeping.		will then be sent to the Physical Plant Director to sign-off on. If any bed fails the checks, the Safety Officer will make out a safety work order and it will be turned over to maintenance to repair immediately.5. Changes completed by:Beds were removed immediatelyPolicy will be approved by QA at the November meeting	

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	The most recent Minimum Data Set (MDS) Assessment dated 9/11/12 indicated Resident #J was assessed with a score of 15 out of a possible 15 for cognition on the Brief Interview for Mental Status (BIMS) and independent with bed mobility and transfers. During the facility wide rounds to review for bed rail safety on 10/24/12 at 2:30 p.m. until 4:00 p.m., Resident #J's bed was observed with bilateral lower rails with areas within the rail that measured 7.5 inches by 9 inches. The bilateral lower rails were not observed in the raised position. 3. The record for Resident #K was reviewed on 10/25/12 at 11:05 a.m. Diagnoses included but were not limited to diabetes, hypertension, depression and dementia/Alzheimer's Disease. The most recent Minimum Data Set (MDS) Assessment dated 8/7/12 indicated Resident #K was assessed with a score of 4 out of a possible 15 for cognition on the BIMS. Resident #K did not report the correct year and did not recall 3 out of the 3 words given for recall. Resident #K was assessed for extensive assistance with two person physical assistance for bed mobility.			

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During the facility wide rounds to review for bed rail safety on 10/24/12 at 2:30 p.m. until 4:00 p.m., Resident #K's bed was observed with bilateral lower rails with areas within the rail that measured 9.25 inches by 7.5 inches, 7.5 inches by 7.5 inches, and 9.25 inches by 7.5 inches. The bilateral lower rails were not observed in the raised position.

4. The record for Resident #L was reviewed on 10/25/12 at 11:10 a.m.

Diagnoses included but were not limited to depression and dementia.

The most recent Minimum Data Set (MDS) Assessment dated 9/16/12 indicated Resident #L was assessed with a score of 11 out of a possible 15 for cognition on the BIMS. Resident #L reported the correct year and recalled 2 of the 3 words given for recall. Resident #L was assessed for extensive assistance with one person physical assistance for bed mobility and transfers.

During the facility wide rounds to review for bed rail safety on 10/24/12 at 2:30 p.m. until 4:00 p.m., Resident #L's bed was observed with a gap between the headboard and the mattress that measured 7.5 inches with the head of the bed down.

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5. The record for Resident #M was reviewed on 10/25/12 at 11:14 a.m.

Diagnoses included but were not limited to hypertension, obesity and congestive heart failure.

The most recent Minimum Data Set (MDS) Assessment dated 10/3/12 indicated Resident #M was assessed with a score of 10 out of a possible 15 for cognition on the BIMS. Resident #M reported the correct day of the week and recalled with cueing 2 of the 3 words given for recall. Resident #M was assessed for supervision and set up assistance for bed mobility and supervision and one person physical assistance for transfers.

During the facility wide rounds to review for bed rail safety on 10/24/12 at 2:30 p.m. until 4:00 p.m., Resident #M's bed was observed with bilateral lower rails with 1 area within each rail that measured 7.5 inches by 9 inches. The bilateral lower rails were not observed in the raised position.

6. The record for Resident #N was reviewed on 10/25/12 at 11:19 a.m.

Diagnoses included but were not limited

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	to history of falls and diabetes. The most recent Minimum Data Set (MDS) Assessment dated 9/5/12 indicated Resident #N was assessed with a score of 13 out of a possible 15 for cognition on the BIMS. Resident #N reported the correct year, the correct month within 5 days and the correct day of the week. Resident #N was assessed for supervision and set up for bed mobility and supervision and set up for transfers. During the facility wide rounds to review for bed rail safety on 10/24/12 at 2:30 p.m. until 4:00 p.m., Resident #N's bed was observed with bilateral lower rails with three areas within each rail that measured 7.5 inches by 9 inches. The bilateral lower rails were not observed in the raised position. 7. The record for Resident #O was reviewed on 10/25/12 at 11:23 a.m. Diagnoses included but were not limited to alcoholic neuropathy, depression and alcoholic encephalopathy. The most recent Minimum Data Set (MDS) Assessment dated 9/19/12 indicated Resident #O was assessed with a score of 14 out of a possible 15 for cognition on the BIMS. Resident #O was			

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	assessed for limited assistance with one person physical assistance for bed mobility and transfers. During the facility wide rounds to review for bed rail safety on 10/24/12 at 2:30 p.m. until 4:00 p.m., Resident #O's bed was observed with a gap between the head board and the mattress that measured 6.5 inches with the head of the bed down. 8. The record for Resident #P was reviewed on 10/25/12 at 11:26 a.m. Diagnoses included but were not limited to diabetes, hypertension and major depression. The most recent Minimum Data Set (MDS) Assessment dated 7/29/12 indicated Resident #P was assessed with a score of 7 out of a possible 15 for cognition on the BIMS. Resident #P did not report the correct time and recalled 2 of the 3 words given for recall. Resident #P was assessed for limited assistance with one person physical assistance for bed mobility and transfers. During the facility wide rounds to review for bed rail safety on 10/24/12 at 2:30 p.m. until 4:00 p.m., Resident #P's bed was observed with bilateral lower rails			

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	with 3 areas within each rail that measured 7.5 inches by 9 inches. The bilateral lower rails were not observed in the raised position. 9. The record for Resident #Q was reviewed on 10/25/12 at 11:29 a.m. Diagnoses included but were not limited to Alzheimer's Disease and neuropathic pain. The most recent Minimum Data Set (MDS) Assessment dated 9/2/12 indicated Resident #Q was assessed with a score of 13 out of a possible 15 for cognition on the BIMS. Resident #Q reported the correct year and the correct month within 5 days and recalled 2 of the 3 words given for recall. Resident #Q was assessed a limited assistance with one person physical assistance for bed mobility and transfers. During the facility wide rounds to review for bed rail safety on 10/24/12 at 2:30 p.m. until 4:00 p.m., Resident #Q's bed was observed with bilateral lower rails with 3 areas within each rail that measured 7.5 inches by 9 inches. The bilateral lower rails were not observed in the raised position. 10. The record for Resident #R was			

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	reviewed on 10/25/12 at 11:33 a.m. Diagnoses included but were not limited to peripheral neuropathy. The most recent Minimum Data Set (MDS) Assessment dated 10/9/12 indicated Resident #R was assessed with a score of 8 out of a possible 15 for cognition on the BIMS. Resident #R did not report the correct year or month and recalled 2 of the 3 words given for recall. Resident #R was assessed as supervision and one person physical assistance for bed mobility and transfers. During the facility wide rounds to review for bed rail safety on 10/24/12 at 2:30 p.m. until 4:00 p.m., Resident #R's bed was observed with bilateral lower rails with 3 areas within each rail that measured 7.5 inches by 9 inches. The bilateral lower rails were not observed in the raised position. 11. The record for Resident #S was reviewed on 10/25/12 at 11:41 a.m. Diagnoses included but were not limited to hemiplegia and joint pain. The most recent Minimum Data Set (MDS) Assessment dated 9/18/12 indicated Resident #S was assessed with a			

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	score of 15 out of a possible 15 for cognition on the BIMS Resident #S was assessed as an extensive assistance with a two person physical assistance for bed mobility and extensive assistance with one person physical assistance for transfers. During the facility wide rounds to review for bed rail safety on 10/24/12 at 2:30 p.m. until 4:00 p.m., Resident #S's bed was observed with bilateral lower rails with 3 areas within each rail that measured 7.5 inches by 9 inches. The bilateral lower rails were not observed in the raised position. 12. The record for Resident #T was reviewed on 10/25/12 at 11:44 a.m. Diagnoses included but were not limited to depression, cerebral vascular accident with hemiparesis and dysphagia. The most recent Minimum Data Set (MDS) Assessment dated 8/17/12 indicated Resident #T was assessed with a score of 0 out of a possible 15 for cognition on the BIMS. Resident #T did not report the correct year, month or day of the week and recalled 0 of the 3 words given for recall. During the facility wide rounds to review			

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	for bed rail safety on 10/24/12 at 2:30 p.m. until 4:00 p.m., Resident #T's bed was observed with bilateral lower rails with 3 areas within each rail that measured 7.5 inches by 9 inches. The bilateral lower rails were not observed in the raised position. 13. The record for Resident #U was reviewed on 10/25/12 at 11:47 a.m. Diagnoses included but were not limited to anemia and mild chronic obstructive pulmonary disease. The most recent Minimum Data Set (MDS) Assessment dated indicated Resident #U was assessed with a score of 2 out of a possible 15 for cognition on the BIMS. Resident #U did not report the correct year, month or day of the week and recalled 1 word with cueing of the 3 words given for recall. During the facility wide rounds to review for bed rail safety on 10/24/12 at 2:30 p.m. until 4:00 p.m., Resident #U's bed was observed with bilateral lower rails with 3 areas within each rail that measured 7.5 inches by 9 inches. The bilateral lower rails were not observed in the raised position.			

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	14. The record for Resident #V was reviewed on 10/25/12 at 11:51 a.m. Diagnoses included but were not limited to cerebral aneurysm with right hemiparesis and hypertension. The most recent Minimum Data Set (MDS) Assessment dated 8/16/12 indicated Resident #V was assessed with a score of 8 out of a possible 15 for cognition on the BIMS. Resident #V reported the correct year, month within 5 days and the incorrect day of the week and recalled 0 of the 3 words given for recall. During the facility wide rounds to review for bed rail safety on 10/24/12 at 2:30 p.m. until 4:00 p.m., Resident #V's bed was observed with bilateral upper rails and bilateral lower rails with 3 areas within each rail that measured 7.5 inches by 9 inches. The bilateral upper rails were observed in the up position. The bilateral lower rails were not observed in the raised position. 15. The record for Resident #W was reviewed on 10/25/12 at 11:55 a.m. Diagnoses included but were not limited to status post traumatic brain injury.			

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	The most recent Minimum Data Set (MDS) Assessment dated 8/30/12 indicated Resident #W was assessed with a score of 12 out of a possible 15 for cognition on the BIMS. Resident #W reported the correct day of the week and the correct month and recalled 3 of the 3 words given for recall. During the facility wide rounds to review for bed rail safety on 10/24/12 at 2:30 p.m. until 4:00 p.m., Resident #W's bed was observed with bilateral lower rails with 3 areas within each rail that measured 7.5 inches by 9 inches. The bilateral lower rails were not observed in the raised position. During an interview on 10/24/12 at 2:22 p.m., LPN #1, the unit manager, was not aware of the specific acceptable measurements regarding bed rail safety. The unit manager called the DoN to come to the resident's bed to evaluate for unsafe zones. During an interview on 10/24/12 at 2:26 p.m., the DoN was not aware of the specific acceptable measurements regarding bed rail safety. The DoN indicated maintenance personnel did a facility wide check for bed rail safety last month, and she was not aware there were unsafe bed rails in the facility.			

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	During an interview on 10/24/12 at 4:00 p.m., the Executive Director [ED] was not aware of the specific acceptable measurements regarding bed rail safety, but the ED recognized 7.5 inches by 9 inches was too large. A facility policy dated 10/23/12 indicated, "...POLICY AND PROCEDURE: Bed Rail Zones, Appropriate Dimensions and Appropriate Usage...It is the intent of the Indiana Veteran's Home that all beds have bed rails with appropriate dimensions per FDA guidelines, so as to avoid any entrapment issues with residents...Per the current FDA guidelines, mattresses may not be further than 4 3/4 inches from the head or footboard of the bed...Per the current FDA guidelines, the bed rail zone can be no greater that 4 3/4 inches wide...." 3.1-45(a)(2)			

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F0386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. Based on interview and record review, the facility failed to ensure physicians wrote a progress note for two visits for 1 of 3 residents reviewed for death (Resident #C). Findings: Resident #C's record was reviewed on 10/23/2012 at 10:00 A.M. Resident #C was admitted to the facility on 12/2/10 and had current diagnoses which included but were not limited to morbid obesity, prostate cancer with a supra pubic catheter, recurrent urinary tract infections, diabetes mellitus, history of atrial fibrillation, history of gastroesophageal reflux, hypertension, anemia, multiple lower extremity wounds, depression, and congestive heart failure with bipedal edema. Resident #C was alert and oriented. He was being followed by a nephrologist regarding the recurrent	F0386	1. What corrective action will be accomplished for those residents who have been found to be deficient by the practice? Physician and Nurse Practitioner were notified of the deficient practice on 10/30/12.2. How will others having the potential to be affected by the deficient practice be corrected?All charts were reviewed for the mandated 30, 60, 90 day visits and the annual visits to assure the progress notes were there and up to date. Results were reported to QA. This was done by 11/5/12. All patient charts were reviewed for orders, progress notes, signatures, dates and times by Physician and Nurse Practitioner. Results reported to QA by Physician and Nurse Practitioner. This will be done by 11/12/12.3. What systemic changes will take place to assure the deficient practice does not occur again?Charts will be pulled on scheduled visit days to separate chart rack for Physician and Nurse Practitioner review. All	11/24/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	urinary tract infections and kidney disease. Resident #C's nurse's notes from 7/1/2012 through 9/12/2012 were reviewed. Resident #C's "Vital Sign Flow Sheet" for the dates 8/20/2012 through 9/8/2012 were reviewed. On 9/6/2012, Resident #C's blood pressure which averaged 100/60 was 62/42 and his oxygen saturation which averaged in the high 90's on room air was 90% on room air. His temperature was documented as 99.3. Documentation of an assessment was lacking in Resident #C's record. The record did not have times of when the vitals were taken or initials of who took the vitals. During an interview on 10/24/2012 at 10:10 A.M., the DON (Director of Nursing) indicated any resident who was being followed by the nephrologist (kidney specialist) had their vitals taken at a minimum of daily. The CNAs (Certified Nursing Assistants) took the vitals and documented them on the frequency form but it was the nurses responsibility to check if they were done and what they were. If the vitals were abnormal the CNAs were to immediately report the vitals to the nurse. The nurse then would assess and notify the physician if needed. If something was		items needing signed, dated or timed will be flagged for the Physician / Nurse Practitioner. Progress notes will be flagged to serve as a reminder to document at each acute visit or regulatory visit. In-servicing will be done with Physician / Nurse Practitioner, and all nurses on new process with charts as well as regulations for documentation by 11/14/12.4. How will changes be monitored for effectiveness?Nursing will monitor the compliance with the 30, 60, 90 day and annual visits on a monthly basis and report compliance to QA, Physician and Nurse Practitioner. All acute visits will be tracked by nursing for the first 30 days for complete orders with date, signature, time, and notes. After 30 days, acute visits will be randomly audited at the sample size of 60% by nursing for 30 days; then 30% for 30d; then 10% of acute visits thereafter. This is to begin for acute visits on 11/5/12.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155787	A. BUILDING 00 B. WING	10/25/2012

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	abnormal for a resident, documentation should be in the nurse's notes and on a notification form the facility filed in a folder for the physician's to look at when they were at the facility. The DON was asked to provide documentation Resident #C was assessed at the time of the abnormal vitals on 9/6/2012. During an interview on 9/24/2012 at 12:20 P.M., the DON indicated she could not find documentation of Resident #C being assessed due to the low blood pressure. She indicated she spoke with the nurse who cared for Resident #C on 9/6/2012 and she could not recall being aware of the abnormal vitals. The DON indicated because there were no initials on the vitals form she could not find out who documented the vitals. The DON indicated two Nurse Practitioners (NP) were here on 9/6/2012. NP #1 addressed Resident #C's indigestion and gave orders for an antacid. The DON called NP #1 and she indicated NP #1 told her she did not recall being told about any abnormal labs. NP #1 did not write a progress note for this visit. The DON called NP #2. NP #2 indicated to the DON she did not remember being told about the abnormal vitals. NP #2 indicated to the DON she only recalled consulting with Resident #C regarding his DNR (do not resuscitate) status. She did not write a progress note			

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	for this visit. This Federal tag relates to Complaint IN00118060 3.1-22(c)(2)			